No. 80-802

In the Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER, PETITIONER

v.

BLUE CROSS OF KANSAS CITY AND BLUE CROSS ASSOCIATION

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether the National Health Planning and Resources Development Act of 1974 creates by implication an antitrust exemption for the voluntary actions of private health care insurance providers, when those actions are neither required by nor essential to the effectuation of any statute or government program, are not regulated by any government agency, and are not encompassed within the exemption from antitrust liability expressly prescribed in the Act.

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INTEREST OF THE UNITED STATES

The United States has an interest in assuring that the National Health Planning and Resources Development Act of 1974, 42 U.S.C. (& Supp. III) 300k *et seq.*, is interpreted and administered in a manner that promotes the congressional health planning policies embodied therein. The United States also has primary responsibility for enforcing the federal antitrust laws. It therefore has an interest in assuring that exemptions from the antitrust laws are not implied unless congressional intent to create such exemptions is clear. To the extent that an antitrust exemption must be implied to avoid frustrating the congressional purpose underlying the National Health Planning and Resources Development Act, the United States has an interest in assuring that the exemption is not broader than necessary and that the policies of both statutes are effectuated to the greatest extent possible.

The United States also has a more specific interest in the issue presented in this case. The extent, if any, to which an antitrust exemption should be recognized under the National Health Planning and Resources Development Act not only will affect law enforcement decisions concerning anticompetitive conduct by insurance providers, hospitals, and others in the health services field, but also will affect the advice given by government agencies to private parties seeking to effectuate the policies of the Health Planning Act while conforming their activities to the requirements of the antitrust laws.

STATEMENT

Legislative Background

1. Congress enacted the National Health Planning and Resources Development Act of 1974 ("NHPRDA") for the purpose of developing a national health policy to be carried out through a system of state and areawide health programs. The statute's ultimate aim was to make quality health care available to all citizens at a reasonable cost. 42 U.S.C. 300k; S. Rep. No. 93-1285, 93d Cong., 2d Sess. 1, 40 (1974).

The new statute, which revised and unified various prior programs,[1] called for a three-tiered regulatory scheme to coordinate federal, state and local efforts. At the federal level, the Secretary of Health, Education, and Welfare (now Health and Human Services) was required to issue guidelines and goals for a national health planning policy on the recommendation of a new permanent body within HEW, the National Advisory Council on Health Planning and Development. 42 U.S.C. 300k-1, 300k-3.

At the local level, Congress created a system of health systems agencies ("HSAs") to serve geographic areas selected by the state governors with the Secretary's ap-

[1] The legislative programs that preceded NHPRDA are reviewed in some detail at S. Rep. No. 93-1285, *supra*, at 4-39.

proval. 42 U.S.C. 300*l*. Congress prescribed that HSA governing bodies must include publicly elected officials as well as consumers and providers of health care services, with a majority representing consumer interests. 42 U.S.C. 300*l*-1. HSAs may be non-profit private corporations, public regional planning bodies, or single units of local government. 42 U.S.C. 300*l*-1(b).[2] They are charged with areawide health planning and development to improve the health of their residents, assure quality health care, restrain increasing costs of such care, and prevent unnecessary duplication of health services. 42 U.S.C. 300*l*-2(a). With the assistance (to the extent practicable) of interested persons in the health service area, HSAs are required to assess their area's health resources, develop long-range health systems plans ("HSPs"), develop short-term implementation plans, review proposed and existing health projects, services, and facilities, and make recommendations to the state agency regarding the need for new services and the appropriateness of existing services. 42 U.S.C. 300*l*-2(b), (c), (f), (g). They also are authorized to approve or disapprove the use of federal funds for specific types of area health projects. 42 U.S.C. 300*l*-2(e).

At the state level, the Act provides for the designation by each governor of a State Health Planning and Development Agency ("State Agency") to develop state health plans on the advice and recommendation of Statewide Health Coordinating Councils ("SHCCs"). The State Agencies are empowered to review the continuing need for existing institutional health services and facilities and to review applications for federal funding of state health programs. 42 U.S.C. 300m-2(a), 300m-3(a). In discharging its planning and review functions, the State Agency is to consider the recommendations of the HSAs. 42 U.S.C. 300m-2(a)(4)-(6).

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[2] More than 200 approved HSAs are now in existence. Approximately 90% of them are non-profit private corporations. S. Rep. No. 96-96, 96th Cong., 1st Sess. 35 (1979).

As one of the conditions for federal funding, the Act requires that a State Agency establish a "certificate of need" program that is satisfactory to the Secretary. 42 U.S.C. 300m-2(a)(4)(B). Under the certificate of need program, HSAs are required to "review and make recommendations" to the State Agency regarding "the need for new institutional health services proposed to be offered or developed in [its] health service area * * *." 42 U.S.C. 300*l*-2(f). The State Agency, in turn, must make determinations as to the need for proposed new institutional health services "[a]fter consideration of recommendations submitted by health systems agencies * * *." 42 U.S.C. 300m-2(a)(5).

2. Congress amended NHPRDA in 1979. See S. Rep. No. 96-96, 96th Cong., 1st Sess. 6 (1979). Having reviewed the strengths and weaknesses of the 1974 legislation, Congress sought to remedy some of the Act's deficiencies. It declared, however, that its aim was to strengthen, not disrupt, the statutory program initiated in 1974. S. Rep. No. 96-96, *supra*, at 8-9. To this end, the 1979 amendments added new controls to planning and certificate of need review, extended certificate of need review to major acquisitions of medical equipment, assured more effective consumer participation in HSAs, conferred damage liability protection on HSAs and SHCC members, and directed that special consideration be given throughout the planning process to the importance of maintaining and improving competition in the health industry. See 42 U.S.C. (Supp. III) 300k-2(a)(17) and (b); 300*l*-1(b)(4)(A)(i); 300m-2(a)(4)(B); 300m-3(d); 300n-1. See also S. Rep. No. 96-96, *supra*, at 2-3, 53, 56-63, 77-80, 85.

The Proceedings Below

Petitioner brought this action against respondents Blue Cross of Kansas City and Blue Cross Association under Sections 1 and 2 of the Sherman Act, 15 U.S.C. 1 and 2, alleging that Blue Cross of Kansas City wrongfully had

refused to accept petitioner as a participating member provider in its health insurance plan. The complaint further alleged that this refusal occurred because petitioner had not obtained a finding of need from Mid-America Health Services Agency ("MAHSA"), a party alleged to be a co-conspirator in the antitrust violation but not named as a defendant in the complaint.[3]

Respondent Blue Cross of Kansas City ("Blue Cross") is a private health services corporation that sells prepaid health care plans to the public in Missouri and Kansas and contracts with health care providers to administer its plans (Pet. App. 20a). Respondent Blue Cross Association is the national parent association of Blue Cross. MAHSA is a private not-for-profit Missouri corporation established as a health systems agency pursuant to NHPRDA.

Petitioner National Gerimedical is a general acute care hospital located in Missouri. Before opening in 1978, it sought to enter into a participating hospital agreement with Blue Cross under which National Gerimedical would receive 100% reimbursement directly from Blue Cross for all services provided to Blue Cross policyholders. Without that contract, National Gerimedical would have to bill Blue Cross subscribers who then would be reimbursed by Blue Cross for only 80% of the hospital bill (Pet. App. 20a).[4]

Although not required to do so by either federal or state law, Blue Cross conditioned its grant of participating membership to a new hospital on the hospital's receipt of a finding from the local HSA (in this case MAHSA) that a new hospital was required to serve a "clearly evident need" for health care services in the

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[3] Petitioner also alleged violations of Missouri's antitrust laws (Pet. App. 18a).

[4] All acute general care hospitals in the Blue Cross service area, except petitioner, have contracted with Blue Cross and are thus "participating" hospitals (Pet. App. 20a).

area (Pet. App. 6a-7a, 21a).[5] Petitioner, however, neither sought nor received MAHSA approval since MAHSA previously had announced that it would disapprove the addition of any new acute care hospital beds (*id.* at 7a, 21a). Consequently, Blue Cross denied National Gerimedical a participating member contract because it had not obtained a finding of "clearly evident need" from MAHSA (*id.* at 20a-21a).

Following Blue Cross's denial of National Gerimedical's application, National Gerimedical filed this action in the United States District Court for the Western District of Missouri. Respondents moved to dismiss the complaint on the ground, *inter alia*, that NHPRDA implicitly repealed the antitrust laws to the extent that the challenged action was undertaken to effectuate the purposes of the Act.[6]

The district court granted summary judgment in respondents' favor and dismissed the complaint (Pet. App. 19a, 44a). It found a clear repugnancy between NHPRDA and the antitrust laws, and concluded that Congress intended that private actions, taken pursuant to NHPRDA and "clearly within [its] scope," be exempt from application of the antitrust laws (*id.* at 37a). In finding a conflict between NHPRDA and the antitrust laws, the court did not measure the challenged conduct against the requirements of NHPRDA. Instead, it concluded that "the entire concept of the * * * Act" revealed that Congress intended to create a blanket antitrust exemption (*id.* at 32a). It added that "the antitrust laws were not intended to apply to members of the health care

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[5] During the relevant time period, the state of Missouri had not authorized a state agency to render "certificate of need" determinations and no certificate of need program was in effect (Pet. App. 7a).

[6] Respondents also claimed that their conduct was exempt from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq.*, and that the prepaid medical plans at issue did not constitute a part of "trade or commerce" within the meaning of

industry clearly acting within the scope of the Act" (*id.* at 33a).[7]

The court of appeals affirmed (Pet. App. 1a-15a). It agreed with the district court that a "clear repugnancy between the Act and the antitrust laws" exists, since "the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim" (*id.* at 11a). The court relied in particular on 42 U.S.C. (Supp. III) 300*l*-2(a)(4) and 300*l*-2(c)(1), which describe as one of the statute's goals the prevention of "unnecessary duplication of health resources," and further provide that each HSA " '*shall* seek, to the extent practicable, to implement its [health plans] with the assistance of individuals and public and private entities in its health service area' " (Pet. App. 3a-9a). The court of appeals also adopted *in toto* the district court's finding that the legislative history revealed congressional intent "to immunize this type of voluntary action from the antitrust laws" (Pet. App. 11a-15a).

SUMMARY OF ARGUMENT

The court of appeals erred in imputing to Congress an intent to immunize from the antitrust laws private conduct which is neither required by nor essential to the effectuation of any statute, which is not regulated by any government body, and which is not encompassed within the express antitrust exemption prescribed by Congress in NHPRDA. In bestowing a broad implied immunity, the court of appeals not only frustrated the policy of open competition embodied in the Sherman Act, but also disregarded the provisions of NHPRDA that pre-

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the Sherman Act (Pet. App. 18a, 38a-39a). Those claims were rejected by both courts below (*id.* at 15a, 22a-27a, 38a-44a), and are not before this Court.

[7] The district court stated that the legislative history showed that "any" attempts to reduce costs and duplication of services by health care providers "were to be welcomed." Pet. App. 34a; see also Pet. App. 12a.

scribe a carefully circumscribed regulatory scheme for barring new hospital entry.

1. It is well settled that an exemption from the antitrust laws may be judicially inferred only when there is a plain repugnancy between the antitrust laws and a subsequently enacted statute on which the implied exemption is based. *FMC* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973). No such repugnancy exists in this case. There is no provision in NHPRDA that required Blue Cross to take steps to create economic barriers to petitioner's entry into the hospital market—the exclusionary conduct challenged in the complaint. And there is no reason to believe that scrutiny of Blue Cross's conduct under the antitrust laws will frustrate any goal of NHPRDA.

NHPRDA places basic planning and advisory functions in the hands of local Health Systems Agencies. Regulatory determinations concerning new entry, however, are entrusted to State Agencies. Local Health Systems Agencies (such as MAHSA) are expected to advise state agencies, but they have no authority to preclude new entry into the health care market by parties such as National Gerimedical. Moreover, NHPRDA delegates no authority of any kind to private parties such as Blue Cross to raise barriers to new hospital entry. In these circumstances, prohibition of private exclusionary conduct in violation of the antitrust laws would reinforce, rather than frustrate, the goals of NHPRDA, since it would reserve the power to allow or deny new entry to State Agencies as envisioned by Congress.

2. Blue Cross also has failed to sustain its weighty burden to establish that Congress intended to displace normal competitive forces with private economic restraints. The terms of NHPRDA evidence no such intent. And the absence of any regulatory supervision of the conduct challenged in this case gives rise to a presumption that Congress did *not* intend to place such conduct beyond the range of antitrust scrutiny. See *Silver* v. *New York Stock Exchange*, 373 U.S. 341 (1963); *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 374 (1973).

The structure of NHPRDA reinforces this presumption. To the extent that State Agencies are entrusted with decisions that could result in economic penalties against a provider, or displace free competition with governmental regulation, the Act prescribes procedures that guarantee notice, opportunity to comment, a fair hearing, and administrative and judicial review. 42 U.S.C. 300n-1(a), (& Supp. III) 300n-1(b). Thus, Congress has demonstrated substantial concern for the fairness of procedures leading to decisions to exclude new entrants such as National Gerimedical. By conferring antitrust immunity on private parties that are not subject to administrative or judicial review, the court of appeals has undermined the sensitive balance fashioned by Congress.

3. Finally, the court of appeals' recognition of a broad implied antitrust immunity cannot be squared with Congress' considered decision to grant only a limited express immunity under NHPRDA. The legislative history shows that arguments in favor of broader antitrust immunity to cover private parties, agents, and consultants of HSAs were made before Congress, but Congress chose to limit liability solely to damage claims against HSAs and members and employees of HSAs and SHCCs. 42 U.S.C. (& Supp. III) 300*l*-1(b)(4), 300m-3(d). In view of this clear expression of legislative intent, and the absence of any evidence that the challenged conduct was necessary to effectuate the statutory scheme, the court of appeals erred in granting an implied immunity that transcends the narrow limitations prescribed by statute. *United States* v. *Borden Co.*, 308 U.S. 188, 201 (1939).

ARGUMENT

AN ANTITRUST EXEMPTION SHOULD NOT BE CREATED BY IMPLICATION IN THIS CASE BECAUSE APPLICATION OF THE SHERMAN ACT TO THE PRIVATE EXCLUSIONARY CONDUCT CHALLENGED IN THE COMPLAINT WOULD NOT CONFLICT WITH OR FRUSTRATE THE GOALS OF THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT

In a long line of cases, this Court has repeated the admonition that implied exemptions from the antitrust laws are disfavored. As noted in *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 218 (1966): "We have long recognized that the antitrust laws represent a fundamental national economic policy and have therefore concluded that we cannot lightly assume that the enactment of a special regulatory scheme for particular aspects of an industry was intended to render the more general provisions of the antitrust laws wholly inapplicable to that industry." Thus, "[r]epeal of the antitrust laws by implication is not favored and not casually to be allowed. Only where there is a 'plain repugnancy between the antitrust and regulatory provisions' will repeal be implied." *Gordon* v. *New York Stock Exchange*, 422 U.S. 659, 682 (1975). See *United States* v. *National Ass'n of Securities Dealers, Inc.*, 422 U.S. 694, 719-720 (1975); *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 787 (1975); *FMC* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973); *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 372 (1973); *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 350-351 (1963).

Repugnancy may be found to exist only when application of the antitrust laws to the practice at issue would frustrate the congressional intent evidenced in a later-enacted regulatory statute. *Gordon* v. *New York Stock Exchange*, *supra*, 422 U.S. at 689-690. "Repeal is to be

regarded as implied only if necessary to make the [subsequent statute] work, and even then only to the minimum extent necessary." *Silver* v. *New York Stock Exchange*, 373 U.S. 341, 357 (1963); accord, *United States* v. *Borden Co.*, 308 U.S. 188, 198, 199 (1939) ("the rule is to give effect to both [statutes] if possible" and "the old law is repealed by implication only *pro tanto* to the extent of the repugnancy"). Examination of the court of appeals' decision reveals that the conduct in question in this case was not measured against the foregoing standards and that, when those standards are applied to the challenged conduct, there exists no plain repugnancy between NHPRDA and the Sherman Act.[8]

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[8] In asserting that respondents' conduct is not immunized from antitrust scrutiny, we do not imply that the conduct violates the Sherman Act. This Court is not faced here with a question of violation, but of immunity. Practices can be non-immune and still be entirely lawful. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 210 n.5 (1979). Following a trial or summary judgment hearing addressed to the merits, respondents' conduct may be found lawful for several reasons. Blue Cross may not have monopoly power in the insurance market in which it operates. Even if it does, its refusal to deal may not have been premised on a desire to abuse its monopoly power either in the insurance market or to gain an advantage in the hospital services market. See *United States* v. *Colgate Co.*, 250 U.S. 300, 307 (1919); cf. *Otter Tail Power Co.* v. *United States*, *supra*, 410 U.S. at 377-378.

The correct resolution of a charge of abuse of monopoly power turns on the economic context in which the conduct occurs. In this case, Blue Cross acts on behalf of its insureds as a purchaser of hospital services from various suppliers, *i.e.*, hospitals. It is difficult to imagine why an enterprise, whether or not a monopolist, would prefer to have fewer rather than more suppliers unless it perceived a likelihood of excessive investment at the supply level which would redound to its detriment in the form of higher costs. Under normal competitive circumstances, additions to capacity or new entry at the supply level would have a tendency to lower prices, whatever the effect on average supplier costs. Thus, when demand is elastic, *i.e.*, sensitive to price, and competitive services are viewed as substitutable, suppliers who overinvest in capacity will be forced to absorb their higher average costs on pain of losing customers. However, where overall demand is inelastic and the

A. Application Of The Sherman Act To The Exclusionary Conduct Challenged In This Case Would Not Conflict With NHPRDA

There can be no repugnancy between the Sherman Act and NHPRDA within the meaning of the decisions described above because NHPRDA neither requires the conduct challenged under the antitrust laws in this case nor depends on that conduct to achieve its objectives. To the contrary, as we demonstrate below, the procedures and safeguards prescribed by Congress in NHPRDA to control new entry are undermined by the court of appeals' immunization of unsupervised private efforts to erect entry barriers in the health care field.

1. The court of appeals conferred antitrust immunity on the acts of private parties seeking to preclude a new hospital from effectively competing to provide health care services. Neither the language nor the legislative history of NHPRDA, however, indicates a congressional intent to *require* such exclusionary private conduct. Blue Cross cannot point to any statutory language that compelled its

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service or product is not viewed as substitutable, this competitive market discipline is diluted and the additional costs of excess investment may be passed on to purchasers. To the extent that the existence of health insurance has reduced significantly the general demand elasticity for hospital services, and individual hospitals are not viewed by patients as substitutable since the choice is often determined by physician affiliation rather than patient choice, the costs of overinvestment in hospital capacity can be passed on to the purchasers of hospital services. In such circumstances, an insurance company which unilaterally sought to discourage excess investment in new hospital capacity in order to reduce costs to its insureds would not, by such action alone, be evidencing any anticompetitive intent. Its purpose, moreover, would be consistent with the congressional desire to avoid unnecessary duplication.

Similarly, petitioner's restraint of trade claim may fail for lack of an agreement (or "concerted conduct") between Blue Cross and any other party. Of course, if petitioner proves that Blue Cross's refusal to offer it participating membership status is the result of an unlawful agreement between Blue Cross and some or all of the other hospitals in the area, it would be entitled to relief under the Sherman Act.

conduct. The only relevant statutory reference to private conduct appears in 42 U.S.C. 300*l*-2(c)(1), which provides:

> The [health systems] agency shall seek, to the extent practicable, to implement its HSP [health systems plan] and AIP [annual implementation plan] with the assistance of individuals and public and private entities in its health service area.

This legislative prompting of HSAs to cooperate with and seek the assistance of private parties hardly can be viewed as a clear directive to private providers to take independent action to "enforce" any exclusionary policy that an HSA espouses. The absence of any such statutory directive was not the product of inadvertence. Under the certificate of need program, the role of HSAs is purely advisory. Only State Agencies may deny new entry on the ground that such entry would produce unnecessary duplication of services (see pages 13-14, 23-25, *infra*). Since Congress withheld from HSAs the power to preclude new entry, it would be anomalous to impute to it an intent to permit—let alone require—private parties to preclude new entry under the guise of implementing HSA recommendations.

2. There is, moreover, no basis for inferring that subjection of Blue Cross's conduct to antitrust scrutiny would frustrate any of NHPRDA's goals. NHPRDA contemplates a carefully interrelated system of federal, state, and local agencies whose function is to assure adequate health care to all Americans, while eliminating unnecessary costs. The state certificate of need programs, which require state approval before new construction or expansion of institutional services can take place, play a central role in this scheme (see S. Rep. No. 96-96, *supra*, at 5). Within the certificate of need framework, the HSAs play an essential advisory role, but have no regulatory powers. 42 U.S.C. 300*l*-2(f), (& Supp. III) 300*l*-2(g)-(h). All their recommendations on certificates of need are reviewed by the State Agency, which alone has

power to deny a request to provide more hospital beds. This separation of powers between the HSAs and State Agencies was deliberate. Congress recognized that (emphasis supplied):

> Although the keystone to the health planning effort envisioned in the proposed Committee legislation is the areawide health planning agency * * * the performance of regulatory functions [is] most appropriately carried out at the State level. *The [regulatory] function can appropriately be carried out only by an agency of State government.*

S. Rep. No. 93-1285, *supra*, at 52; *accord*, S. Rep. No. 96-96, *supra*, at 67.

Under NHPRDA, therefore, MAHSA had no power to deny a certificate of need with preclusive effect on new entrants. Only the state of Missouri could exercise that power, after reviewing MAHSA's recommendation. Since Congress denied HSAs the power to erect barriers to new hospital entry, denying such power to private parties who purport to enforce HSA recommendations would not frustrate the statutory scheme.

3. Instead of analyzing the overall statutory scheme described above, the court of appeals seized on isolated phrases in the statute to support the view that Blue Cross's conduct was "clearly call[ed] for" by NHPRDA (Pet. App. 11a).[9] The court placed principal reliance on 42 U.S.C. (Supp. III) 300*l*-2(a)(4), which calls on health systems agencies to formulate plans with a view toward preventing "unnecessary duplication of health resources" (Pet. App. 3a). The court also relied on 42 U.S.C. 300*l*-2(c)(1), which directs HSAs to "seek, to the extent practicable," to implement their health plans "with the assistance of individuals and public and private entities in [their] health service area."

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[9] The district court concluded, with less certainty, that Blue Cross's certificate of need requirement "*seems to be authorized* by the Act" (Pet. App. 32a; emphasis added).

The statutory goal of avoiding "unnecessary duplication," however, is only one of many goals to be considered in evaluating proposals and making plans. See 42 U.S.C. 300k, (& Supp. III) 300k-2 and 300*l*-2(a).[10] These goals, although important, are broadly stated and quite general. While such generality is acceptable, perhaps even unavoidable, when delegating authority to an administrative agency, it hardly reflects a congressional judgment that a broad category of voluntary private conduct must be immunized from the antitrust laws if the public interest in health care is to be fostered. The statutory desire to reduce "unnecessary" duplication, of course, is not self-defining. If all duplication were deemed undesirable, the adjective "unnecessary" would not have been included. Determining the point where duplication ceases to be desirable requires a careful balancing of sometimes conflicting values, *e.g.*, facilitating consumer choice versus limiting short term costs. Moreover, in those instances where Congress determined that it would serve the public interest to supplant competitive entry with a certificate of need program, it vested the responsibility to balance these values in responsible State Agencies, not in private parties. When new entry is denied by government authorities after balancing these various public interest values, the statute provides explicit procedural safeguards, including judicial review of administrative action. 42 U.S.C. 300n-1(a), (& Supp. III) 300n-1(b). The fact that Congress prescribed such pervasive procedural safeguards in the certificate of need program "refutes the argument that private controls of competition are necessary in the public interest and ought therefore to be immune from scrutiny under the antitrust laws." *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 352 (1963).

Nor is there merit in the court of appeals' conclusion that the statutory mandate that HSAs "seek the assist-

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[10] 42 U.S.C. (& Supp. III) 300k-2(a) lists seventeen national health priorities.

ance" of private entities requires a displacement of the antitrust laws.[11] Congress plainly intended to encourage communication between the public and HSAs, but parties may consult with HSAs and give their views on health planning issues without abusing monopoly power or entering into unlawful agreements in restraint of trade, as alleged in the complaint in this case.[12]

4. While relying on the general statutory language discussed above, the court of appeals disregarded the only

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[11] To be sure, there are some activities that must, by implication, be immune from antitrust attack if HSAs and State Agencies are to exercise their authorized powers. Since the Act requires HSAs, in developing their plans, to seek the assistance of private parties, consultation with an HSA in the planning process would be protected. Similarly, there may be occasions in implementing health systems plans when an implied exemption might be necessary in order to effectuate the statutory scheme as required by Congress. But under the Act, the forum for developing a health systems plan is an open one. The HSA is required to conduct a public hearing on its proposed health plan, and to offer the opportunity for oral and written comment. The final plan must be consistent with federal guidelines or the HSA must explain why it is not. 42 U.S.C. (Supp. III) 300*l*-2(b)(2). Thus, HSA decisionmaking is public and open, and carefully supervised.

[12] Congress expressed concern over abuses by health providers in the planning process. Thus, while recognizing that area health service providers (including "insurers"—42 U.S.C. 300n(3)(B)(iv)) should participate in health planning, Congress noted that, because of the potential for conflicts of interest with respect to HSA recommendations, "their influence on the health planning process must be appropriately limited." S. Rep. No. 93-1285, *supra*, at 46.

Congress also expressed concern about provider domination of planning agency decisions under prior programs, and sought to curtail it, in part by limiting provider representation on HSA governing boards. S. Rep. No. 96-96, *supra*, at 4-5; 42 U.S.C. 300*l*-1(b)(3)(C). To further check provider abuse of the planning process, the 1979 amendments added conflict of interest provisions to prevent providers serving on HSA boards or SHCCs from voting on matters in which they have a financial interest. Pub. L. No. 96-79, 93 Stat. 606; 42 U.S.C. (Supp. III) 300m-3(e).

statutory language that specifically refers to competition. 42 U.S.C. (Supp. III) 300k-2(a)(17), prescribes as a national health priority the "strengthening of competitive forces in the health services industry" when competition can serve the public interest. Indeed, the 1979 Senate Committee Report viewed the promotion of competition in the health services industry to be as important as encouraging cost containment.[13] In furtherance of the goal of increased competition, 42 U.S.C. (Supp. III) 300k-2(b)(1)-(3) calls for promotion of competition when it can serve the public interest, and HSAs are directed to chart their course with a view to "preserving and improving, in accordance with section 300k-2(b) of this title, competition in the health service area." 42 U.S.C. (Supp. III) 300*l*-2(a)(5).[14] The court of appeals' failure to

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[13] See S. Rep. No. 96-96, *supra*, at 85 (emphasis supplied):

> The Committee realizes that since initiation of the Act, the orientation of the planning process has become increasingly centralized, threatening to leave out competition altogether. With these provisions, the Committee introduces into the health planning law the recognition *that planning agencies at all levels have as important a responsibility to promote competition among health care providers as the obligation to encourage cost containment, facility closure or shared services.* The experience with other public regulatory authorities has been one of creating industry cartels which emphasize market stability rather than innovation and consumer preference. The Committee intends to protect against such tendencies in health sector regulation.

[14] Sections 300k-2(a)(17), 300k-2(b)(1)-(3), and 300*l*-2(a)(5) were added to NHPRDA in 1979. The legislative history shows that the endorsement of competition in 1979 was not a change in underlying statutory design. See S. Rep. No. 96-96, *supra*, at 5, 8-9, 50, 52 (noting that these amendments are designed to strengthen the "basic character and structure of the health planning program * * *"). There is no indication that the later Congress believed that its predecessor had rejected competition and the antitrust laws in the health care field.

Indeed, Jacob Getson, a member of the Board of Directors of the American Health Planning Association, the national association for

recognize the important role that competition plays under NHPRDA, as evidenced by these provisions, undoubtedly contributed to its misreading of the legislative intent.[15]

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state and local health planning agencies, testified during hearings on the 1979 amendments that

> health planning agencies can and should use their Health Systems Plan, Annual Implementation Plans, and related implementation activities to promote and encourage the marketplace forces and fair competition in health care in these communities. We believe that this can be done under the present law without amendment. It would be desirable to provide additional clarification in the report to accompany the bill that such activities are desirable when they serve to advance such purposes as cost moderation, quality assurance, accessibility and responsiveness to consumer preference.

Hearings on H.R. 3041 and H.R. 3167 Before the House Subcomm. on Health and the Environment of the Comm. on Interstate and Foreign Commerce, 96th Cong., 1st Sess. 171, 177 (1979) (hereinafter referred to as "*Hearings*").

[15] The courts below pointed to congressional concern over increasing hospital costs and improper utilization of existing facilities (Pet. App. 11a-13a, 33a-34a), and Committee Reports calling for prevention of unnecessary duplication of resources and implementation of health plans with assistance from the private sector (*ibid.*). Those congressional materials, however, simply restate the provisions of the bill that ultimately were enacted. They add no different gloss to the statutory language.

Both lower courts placed considerable reliance on remarks of Rep. Rogers in debates preceding the 1979 amendments (Pet. App. 14a-15a, 34a-35a). That reliance is misplaced. First, the remarks were made in debates on H.R. 11488, 95th Cong., 2d Sess. (1978), a health planning amendments bill that did not pass the 95th Congress, and which contained no reference to competition at all, as did its successor—S.544, 96th Cong., 1st Sess. § 154 (1979). Thus, even if directed at the type of case presented here, Rep. Rogers' individual views do not bear the weight given them by the lower courts in light of the fact that the 96th Congress enacted amendments specifically endorsing competition and rejected suggestions that comprehensive immunity from the antitrust laws be extended to private parties acting in cooperation with health planning bodies (see pages 25-27, *infra*).

Nor are Rep. Rogers' remarks evidence of Congress's original intent in enacting NHPRDA for, as this Court frequently has held,

5. In its Brief in Opposition to the Petition for a Writ of Certiorari (Br. in Opp. 14-16), respondent Blue Cross Association distinguishes 42 U.S.C. (Supp. III) 300k-2(b)(2) from 300k-2(b)(3) in order to advance the argument that Congress intended the 1979 amendments to foreclose competition for "inpatient" health services while promoting competition with respect to "outpatient" services.[16] This, however, is a misreading of the statute, and in any event does not advance BCA's immunity argument regarding private parties. While Congress recognized that free competition in certain segments of the health services

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opinions of individual legislators voiced after passage of legislation should be accorded little weight. *United States* v. *Philadelphia National Bank, supra*, 374 U.S. at 348-349; *United States* v. *United Mine Workers*, 330 U.S. 258, 282 (1947). Rep. Rogers' remarks fail to indicate a clear Congressional intent to create a broad antitrust exemption for yet another reason: they were made to counter statements by others that NHPRDA did *not* bestow antitrust immunity sufficient to exempt all cooperative efforts of hospitals and HSAs. 124 Cong. Rec. H11962 (daily ed. Oct. 10, 1978). Finally, Rep. Rogers did not address the situation presented here—the action of Blue Cross in granting and withholding its own participating member contracts. Rather, he was addressing a situation in which private parties were merely participating in HSA activities, as contemplated by the NHPRDA. See note 11, *supra*.

[16] 42 U.S.C. (Supp. III) 300k-2(b)(2) and 300k-2(b)(3) provide as follows:

> For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this subchapter take actions * * * to allocate the supply of such services.
>
> For the health services for which competition appropriately allocates supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this subchapter give priority * * * to actions which would strengthen the effect of competition on the supply of such services.

market, such as institutional inpatient services, might not always efficiently allocate supply, it did not foreclose competition in that institutional setting if competition is in fact found to be working.[17] Congress merely provided that, while competition generally should receive priority in health planning, planning bodies may displace competition and allocate supply themselves in cases where free market forces do not allocate supply in an efficient manner. Moreover, if competitive forces are not working effectively, it is State Agencies, not private parties, which possess statutory authority to allocate supply through grants and denials of certificates of need. See 125 Cong. Rec. H8234 (daily ed. Sept. 20, 1979) (remarks of Rep. Staggers).

The fact that Congress recognized the need to impose entry restrictions on new hospital construction—in the form of a certificate of need program—does not by itself evince an intent to displace the antitrust laws.[18] The

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[17] The Senate Committee Report stated:

> Despite the fact that the health care industry has not to date responded to classic marketplace forces, the committee believes that the planning process—at the Federal, State, and local level—should encourage competitive forces in the health services industry wherever competition and consumer choice can constructively serve to advance the purposes of quality assurance and cost effectiveness.

S. Rep. No. 96-96, *supra*, at 53.

[18] It is well-settled that "[a]ctivities which come under the jurisdiction of a regulatory agency nevertheless may be subject to scrutiny under the antitrust laws." *Otter Tail Power Co.* v. *United States*, *supra*, 410 U.S. at 372. Accord, *Ricci* v. *Chicago Mercantile Exchange*, 409 U.S. 289, 302 n.13 (1973) (Commodity Exchange Act regulation of membership on the Exchange does not "confer general antitrust immunity on the Exchange and its members with respect to that area of conduct within the adjudicative or rulemaking authority of the Commission or the Secretary"); *Maryland & Virginia Milk Producers Ass'n* v. *United States*, 362 U.S. 458, 466-467 (1960) (regulation of a dairy cooperative by the Secretary of Agriculture under the Capper-Volstead Act does not immunize the cooperative against all monopolization and conspiracy charges).

Communications Act of 1934, 47 U.S.C. 309, similarly limits entry into broadcasting, but that factor is not sufficient to establish a congressional intent to displace the antitrust laws. *United States* v. *R.C.A.*, 358 U.S. 334 (1959). In industries where Congress has chosen both to limit entry and displace the antitrust laws, it has conferred express exemption power on the agency. See, *e.g.*, 49 U.S.C. 1384 (Federal Aviation Act); 49 U.S.C. (Supp. III) 10706 (Interstate Commerce Act). Absent express exemption authority, even formal agency approval of conduct not necessary to effectuate the statutory scheme does not immunize private anticompetitive conduct. See, *e.g.*, *California* v. *FPC*, 369 U.S. 482, 486, 490 (1962) (Federal Power Commission approval under the Natural Gas Act of certain acquisitions does not displace the Clayton Act); *United States* v. *R.C.A.*, *supra*, 358 U.S. at 346, 350-351 (Federal Communications Commission approval of an exchange of television stations does not immunize the transaction from antitrust challenge); *United States* v. *Philadelphia National Bank*, *supra*, 374 U.S. at 350-355 (approval of a bank merger by banking regulators does not foreclose antitrust scrutiny).

Since official approval is not sufficient by itself to confer an antitrust exemption on what essentially is voluntary private conduct, it follows *a fortiori* that the antitrust laws are not rendered inapplicable in this case simply because Blue Cross may have believed that its alleged exclusionary practices were in furtherance of a general regulatory purpose such as avoiding unnecessary expenditures or duplication of services. See *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 227-228 (1940) ("The fact that the [defendants'] buying programs may have been consistent with the general objectives and ends sought to be obtained under the National Industrial Recovery Act is likewise irrelevant to the legality under the Sherman Act of [their] activities * * *").

B. The Court Of Appeals Erred In Imputing To Congress An Intent To Confer On Private Parties Unsupervised Power To Engage In Anticompetitive Acts

In seeking to impute to Congress an unexpressed intent to displace the fundamental national economic policy embodied in the antitrust laws, respondents bear a heavy burden. Respondents' burden is particularly heavy in this case since their argument attributes to Congress an intent to commit unsupervised public power to private hands, contrary to the traditional allocation of economic regulatory power in our free enterprise system.

In *Silver* v. *New York Stock Exchange*, *supra*, 373 U.S. at 357-367, this Court considered the activities of a stock exchange that Congress had authorized to engage in some measure of private self-regulation. The Court concluded that the failure of Congress to provide regulatory supervision over the specific conduct challenged under the antitrust laws established that there was not a sufficient conflict between the regulatory scheme and the antitrust laws to support an implied exemption. The Court's decision reflected the principle that private parties may not arrogate to themselves authority to impose significant restraints on competition, even if they purport to serve the public interest. Such authority is public in nature: it is not lightly entrusted to private hands. *Fashion Originators' Guild* v. *FTC*, 312 U.S. 457, 465 (1941) ("the combination is in reality an extra-governmental agency, which prescribes rules for the regulation and restraint of interstate commerce, and provides extra-judicial tribunals for determination and punishment of violations, and thus 'trenches upon the power of the national legislature and violates the statute' ") ; accord, *Associated Press* v. *United States*, 326 U.S. 1, 19 (1945). Private parties seeking to exercise such powers must establish clearly that Congress intended such an exceptional result, and even then procedural fairness must be afforded to persons who may be ad-

versely affected.[19] Neither the requisite congressional intent to confer private exclusionary power, nor safeguards against its abuse, are found in NHPRDA.

To the contrary, as we have noted above, NHPRDA places the process of health planning and implementation in the hands of HSAs and governmental bodies. In carrying out their duties under a certificate of need program, HSAs and State Agencies are required by statute to follow established guidelines and employ prescribed procedures, subject at every level to administrative oversight or judicial review. Congress contemplated that private parties, such as Blue Cross, would be participants in a system of voluntary cooperation, where motivations "are governed in the first instance by business judgment and not regulatory coercion * * *." *Otter Tail Power Co.* v. *United States, supra*, 410 U.S. at 374. As to these private parties, "courts must be hesitant to conclude that Congress intended to override the fundamental national policies embodied in the antitrust laws." *Ibid.*

This caveat applies with particular force here. NHPRDA does not give even HSAs or State Agencies unfettered authority to bar new entry into the health services field. HSA recommendations to refuse certificates of need are advisory only. 42 U.S.C. 300*l*-2(f). They must be referred to the State Agency for a final decision. 42 U.S.C. (& Supp. III) 300m-2(a)(4) and 300m-2(a)(5). Moreover, all certificate of need decisions must be consistent with a State Health Plan (42 U.S.C. (Supp. III) 300m-6(a)(5)) and state certificate of need programs must be consistent with standards adopted by the Secretary of HHS. *Ibid.* At both the HSA and State Agency levels, there are opportunities for notice and com-

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[19] *Silver* v. *New York Stock Exchange, supra*, 373 U.S. at 361-364; L. Sullivan, *Antitrust* 251 (1977); III P. Areeda & D. Turner, *Antitrust Law*, ¶ 736e (1978) ("Refusal to deal for political or social reasons amounts to private imposition of sanctions or disabilities which may well, for constitutional reasons, be beyond even legislative power").

ment, and at least one formal hearing (42 U.S.C. 300n-1 (a) and (& Supp. III) 300n-1(b)).[20] Moreover, any final decision to deny an application is judicially reviewable for arbitrariness, capriciousness, or failure to comply with the law. 42 U.S.C. (Supp. III) 300n-1(b)(12)(E).[21]

Thus, to the extent NHPRDA sanctions decisionmaking by State Agencies that might conflict with antitrust policies, the Act provides procedural safeguards and avenues of review to assure that the required balancing of public interest considerations is effectuated in an open forum in full compliance with statutory standards of fairness. In the present case, Blue Cross allegedly imposed an economic sanction on petitioner without the intermediation of any government body. MAHSA, whose policy Blue Cross purported to promote, lacked such power.[22] Under the statutory scheme, MAHSA could only recommend that a state agency foreclose new entry. Neither the statute,

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[20] The Senate bill contained a provision, not included in the House amendment, requiring hearing procedures to be consistent with State administrative law. The conference committee adopted the Senate version, emphasizing that the hearing must be independent of the State planning agency. H.R. Conf. Rep. No. 93-1640, 93d Cong., 2d Sess. 75 (1974). The conference committee also adopted a House amendment to the Senate bill that required the Secretary to review State Agency activities. *Id.* at 82. Those administrative safeguards were provided to assure that review procedures by HSAs and State Agencies be "equitable to all those affected." H.R. Rep. No. 93-1382, 93d Cong., 2d Sess. 84-85 (1974).

[21] In adding a mechanism for judicial review of final State Agency decisions on certificates of need, Congress also provided that the procedural requirements of Section 300n-1(b) may, as appropriate, apply to other review programs. 42 U.S.C. (Supp. III) 300n-1(b)(12). The House Conference Committee explained that *any* review that would prevent a health care institution from providing a service or impose similar economic disabilities should be subject to these procedural safeguards. H.R. Conf. Rep. No. 96-920, 96th Cong., 1st Sess. 77 (1979).

[22] Indeed, respondents do not even contend that they communicated with MAHSA concerning their denial of participating membership to petitioner National Gerimedical.

nor its legislative history, provides any support for granting private providers like Blue Cross more power than MAHSA possessed. In these circumstances, the court of appeals' decision immunizing exclusionary conduct of the kind alleged in the complaint undercuts, rather than promotes, the manifest purposes of the statute.

C. The Court Of Appeals Erred In Recognizing A Broad Implied Repeal Of The Antitrust Laws In The Face Of Statutory Language Conferring A Narrow And Carefully Circumscribed Antitrust Exemption

The court of appeals also failed to give effect to the well-established rule, frequently enunciated by this Court, that when a federal statute explicitly immunizes specific activities from the antitrust laws, that "show[s] beyond question how far Congress intended that the * * * Act should operate to render the Sherman Act inapplicable. If Congress had desired to grant any further immunity, Congress doubtless would have said so." *United States* v. *Borden Co.*, *supra*, 308 U.S. at 201; *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 216-218 (1966); see also *California* v. *FPC*, 369 U.S. 482, 485 (1962). In such cases, the terms of the express exemption themselves provide additional evidence that application of the antitrust laws to conduct not specifically immunized would not frustrate Congress's regulatory purpose. This rule of construction, while not immutable, places a heavy burden on those who would argue that Congress intended to immunize conduct not encompassed within the express exemption. And the burden is particularly heavy here since NHPRDA not only contains a limited express exemption, but its legislative history indicates that Congress deliberately rejected proposals to grant broader immunity.[23]

As originally enacted in 1974, NHPRDA contained a single provision limiting liability. 42 U.S.C. (& Supp. III) 300*l*-1(b)(4), provided that individual members

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[23] As previously noted, the immunity sought to be implied in this case is not necessary to make the health planning statute work as Congress envisioned. See note 11, *supra*.

or employees of HSAs would not be liable for damages under any federal or state law based on activities authorized under the Act, if performed with due care and without malice.

In 1979 the scope of protection against liability for damages was extended to HSAs themselves and to individual members or employees of SHCCs. 42 U.S.C. (Supp. III) 300*l*-1(b)(4)(A), (B), 300m-3(d).[24] The legislative history indicates that, while the Senate bill would have extended such immunity to private consultants or agents of HSAs and SHCCs as well, the Conference Committee rejected that portion of the amendment. H.R. Conf. Rep. No. 96-420, *supra*, at 66; S. Rep. No. 96-309, 96th Cong., 1st Sess. 67 (1979).[25]

During hearings on the 1979 amendments before the House Health Subcommittee, the American Health Planning Association proposed an amendment that would have extended immunity from damage liability not only to members and employees of HSAs and SHCCs but to "agents who voluntarily follow the recommendation of a [State Agency] or HSA made in conformance with the requirements of this act * * *." *Hearings*, *supra*, at 177, 181, 187-188. The Central Virginia Health Systems

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[24] Damage immunity for HSA members and employees was broadened somewhat as well. The 1974 Act exempted acts performed "within the scope of [their] duty * * * exercised [with] due care * * *." 42 U.S.C. (& Supp. III) 300*l*-1(b)(4). The 1979 amendments exempt acts performed "without gross negligence" "if [the defendant] believed he was acting within the scope of his duty * * *." 42 U.S.C. (Supp. III) 300*l*-1(b)(4)(A)(ii).

[25] In hearings on the 1979 amendments, Hale Champion, Undersecretary of HEW, testified that it was his belief that HSAs are immune from antitrust challenge for decisions made pursuant to their statutory mandate (*e.g.*, recommendations concerning certificates of need). He asserted, however, that if HSAs delegate their decisionmaking authority to private parties (*e.g.*, providers), immunity for decisionmaking is lost. *Hearings*, *supra*, at 161. Congress apparently agreed with this interpretation. For, while it extended immunity to HSAs themselves, it rejected proposals to grant immunity to private parties acting as consultants or agents of the HSAs.

Agency also urged that antitrust immunity be extended to providers who work with planning agencies. *Id.* at 701; see also *id.* at 641 (suggestion of the American Medical Association that "[a] new section * * * be added to exempt actions taken in meeting the requirements of the Act from federal antitrust laws"). Despite these urgings, Congress chose to adopt narrowly drawn exemptions, extending immunity only to HSAs and members and employees of HSAs and SHCCs. The express immunity is, moreover, limited to damage actions; injunctive relief is still available.

Thus, Congress carefully considered the extent to which it intended to bestow immunity. It was aware that health providers and insurance companies like Blue Cross would participate with HSAs and their employees in health planning activities. But it chose not to clothe them with general immunity. In view of the measured provision of immunity to certain persons, the absence of an express exemption for others like Blue Cross may not be attributed to congressional inadvertence.

CONCLUSION

The decision of the court of appeals should be reversed.

Respectfully submitted.

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